SOCIETY OF ACTUARIES
HEALTH SECTION

HEALTH WATCH
DECEMBER 2019

New Contract Medicare Star Ratings: Why the Sudden Cliff?

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Medicare Advantage and Part D health plans are offered by private Managed Care Organizations (MCOs) that contract with Medicare. These plans provide all of the combined Part A and Part B benefits, known as Part C, and they often cover Part D benefits as well. Over the last 10 years, these plans have become very popular, with a large number of Medicare beneficiaries choosing to switch to a Medicare Advantage plan. As such, many MCOs have chosen to offer new contracts in the Medicare Advantage market space each year.

Medicare uses a Star Rating System to measure how well Medicare Advantage and Part D contracts perform in various quality measures. Higher performing contracts receive more Medicare revenue, which can be used to enhance benefits and/or reduce premiums for their members. Star Ratings range from 1.0 (low) to 5.0 (high), and contracts with a Star Rating of 4.0 or higher receive a Quality Bonus Payment (QBP) of 5% of the benchmark Medicare rate. If a plan is offered in a double bonus county, then the plan will receive a QBP of 10% of the benchmark Medicare rate. New contracts do not have the historical performance information necessary to determine a Star Rating, so they are temporarily assigned a 3.5% bonus payment for the first three years. After three or more years, contracts begin to receive a Star Rating based on their historical performance. Historically, more than 75% of contracts receive an initial Star Rating after this time that results in the removal of their QBP payment because they are unable to reach the 4.0 Star Rating. The article that follows attempts to better understand this Star Rating "cliff" by stratifying new contracts based on parent organization size and initial enrollment growth, then identifying the key quality measures that contribute to this decline in Star Ratings for a new contract.

Throughout this paper, we will focus on defining the disparity in Medicare Advantage Star Ratings between contracts receiving their first star ratings ("New" contracts) and existing contracts, including:

1. Understanding what happens to Medicare Advantage Payments when contracts receive lower star ratings?—**What is the Star Rating cliff and why does it matter to new contracts?**

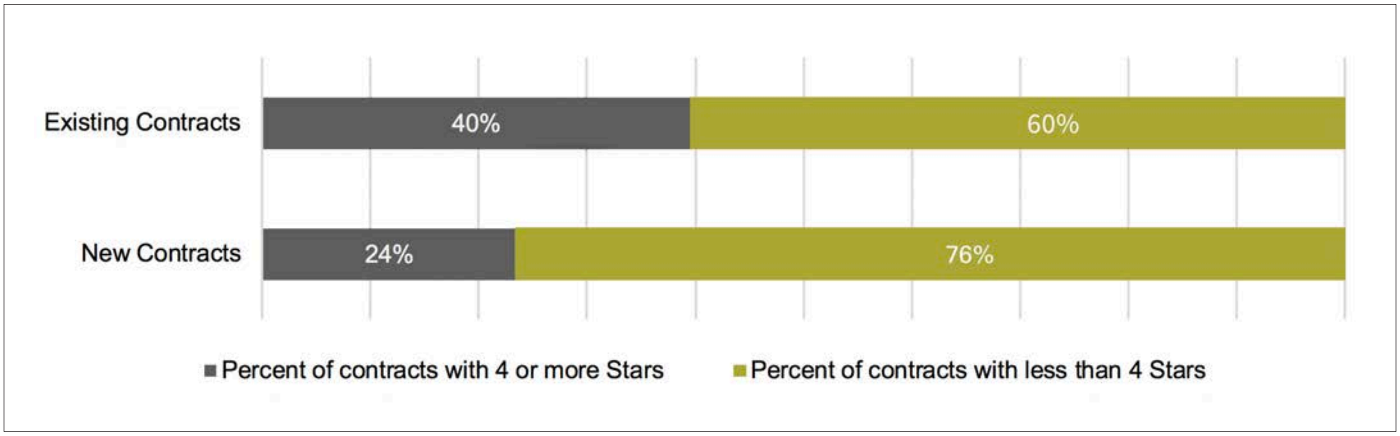
2. Explaining *when* a contract receives their first star rating and how much enrollment this requires—**When does the Star Rating cliff occur?**

3. Noting which specific star measures "New" contracts struggle with, including those contracts under large parent organizations, contracts with rapid growth, and all other new contracts—**How can my contract avoid the Star Rating cliff?**

MEDICARE STAR RATINGS—A COMPARISON

On average,[1] contracts receiving their first star rating receive 3.20 stars, compared to existing or established contracts receiving 3.90 stars on average. This 0.70 disparity in quality ratings creates significant hardship on new contracts when this lower star rating decreases their payments in the following calendar year. Further, of all "New" contracts receiving their first star rating, only 24% of contracts receive 4 stars or higher, resulting

Figure 1
Contracts Receiving 4+ Stars



in a 5% QBP or 10% QBP in double bonus counties. This is compared to existing contracts of which 40% receive 4 stars or higher and a resulting QBP. These results can be seen in Figure 1.

Star Rating Impacts on Medicare Revenue

What Is the Star Ratings Cliff and Why Does It Matter?

Before a contract receives their first MA Star Rating, they are deemed a "New" Contract by CMS. They will either be paid based on an enrollment weighted average star rating of their parent organization, or will qualify as a "New Contract under a New Parent Organization" and will receive a 3.5% quality bonus payment and 65% rebate. When these contracts then receive their first star rating based off their own performance, it often results in a lower Quality Bonus Payment and/or rebate than was previously received. This decrease in revenue is referred to in this paper as the "Star Rating Cliff."[2]

Appendix B of this paper shows how star ratings impact Medicare Advantage payments through varying Quality Bonus Payments (QBP) applied to Benchmarks and varying rebate percentages.

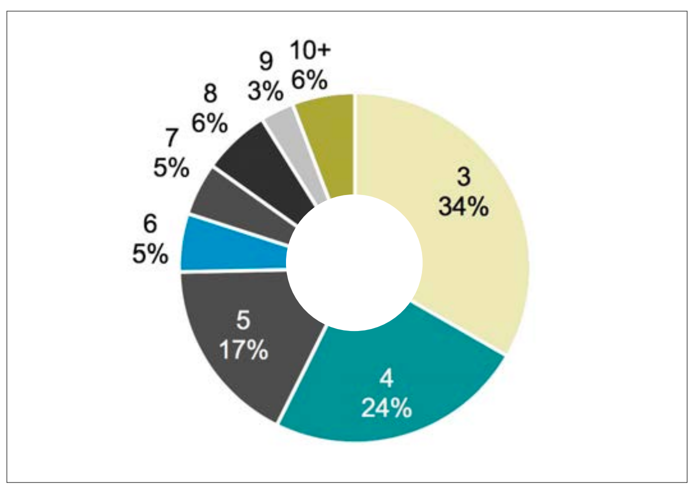
This higher revenue driven by higher star ratings can give contracts more strategic options, resulting in a competitive edge on sales and membership. Although only 38% of all Medicare contracts are deemed as "High Performing" (Star Rating of 4.0 or higher), over 57% of members are enrolled in high performing contracts. The large amount of membership in High Performing contracts illustrates the advantage these contracts have to enroll and retain Medicare members. Additionally, the average contract enrollment for contracts below 4.0 stars is just under 24,000 members. The average contract enrollment for contracts with 4.0 stars or greater is over 50,000 members (high performing contracts are over twice as big!).

The Progression From Performance to Star Rating

When Does the Star Rating Cliff Occur?

The first year that a plan can receive a Star Rating is three years after the performance data is collected. For example, a plan that is new in coverage year 2018 may have its first Star Rating no earlier than 2020, which will affect payments in year 2021. Further detail around the Star Rating timeline can be found in Appendix A of this paper. Stars measures require a contract to have a minimum number of members in order to be credibly measured, and many plans do not have enough membership in their first year. Figure 2 illustrates the amount of time between a plan's first coverage year and the first payment year that the plan receives a Star Rating. Approximately one-third of plans receive a Star Rating payment in the first year that they are eligible, which is three years after their first year of coverage.

Figure 2
Distribution of Contracts Based on Number of Years Between First Coverage Year and First Star Rating Payment



The amount of enrollment required for a contract to receive an individual measure Star Rating depends on the specific measure and the enrollment included in measuring the contract performance. Therefore, the enrollment required to earn an Overall Star Rating will vary by contract. On average, for contracts with low SNP Enrollment[3], approximately 20% of contracts between 500 and 1,000 members will receive enough individual measure Star Ratings to earn an overall Star Rating and more than 80% of contracts between 1,000 and 1,500 members will earn an Overall Star Rating. These numbers vary slightly for contracts with a high percentage of SNP enrollment (20% and 70%, respectively). Figure 3 below shows further detail on the percentage of contracts that receive an Overall Star Rating at each enrollment level.

Which Performance Measures Tend to Drive Down a New Plan's Star Rating?

How Can My Plan Avoid the Star Rating Cliff?

New plans are not all the same and do not all face the same challenges in Stars performance measures. Contracts receiving their first star rating were broken into three categories for this study:

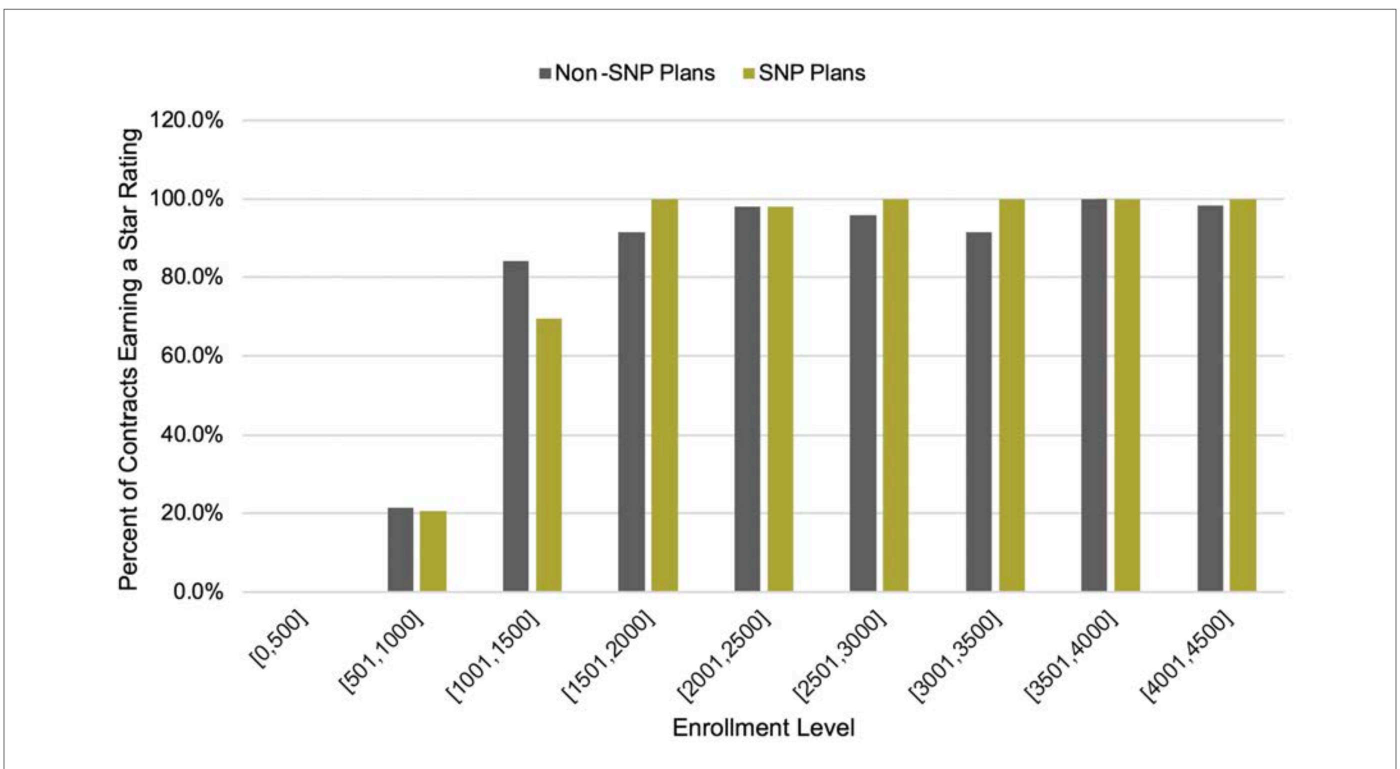
- "New" contracts belonging to large parent organizations.[4] These contracts often have more resources to devote to star ratings compared to smaller or less mature parent organizations.
- "New" contracts receiving a star rating in the first year that they are eligible. These contracts may have faster enrollment growth and will not receive "improvement" star measures in their first star rating year.
- Other "new" contracts

Based on a comparison in measure-level performance between these "New" contract categories and "Existing" contracts:

- **Across all "New" contract categories,** plans consistently under-perform in two Stars measures: Diabetes Care—Blood Sugar Controlled and Controlling Blood Pressure. Combined, these measures drive a new contract's weighted average Star rating down by approximately 0.12, relative to existing contracts.
- **New contracts with large parent organizations** tend to under-perform in customer satisfaction measures, including Customer Service, Complaints about the Health Plan, and Members Choosing to Leave the Plan.
- **Fast growing contracts,** or contracts that receive their first Star rating after three years, under-perform in drug-related process measures. In particular, these contracts under-perform in the statin therapy and medication adherence measures.

Figure 3

Percent of Contracts With Star Ratings by Enrollment Level



- **Other new contracts,** which grow at a slower pace and take longer than three years to receive their first Star Rating, struggle to achieve continuous improvement each year. These contracts under-perform in the Health Plan and Drug Plan quality improvement measures. These improvement measures are likely issues for fast growing contracts as well, beginning in their second year.

Detailed results showing the top 5 most impactful measures for each of these categories are shown in Appendix C.

CONCLUDING THOUGHTS

The difference in rating between contracts receiving their first overall star and existing contracts is significant (0.70 stars on average). And if "new" contracts wait until they receive their first rating to act upon this information, it will take at least three years for their payments to rebound. New contracts that drop off the Star Rating cliff will need to adjust premiums and benefits to maintain profit, which will make it harder to remain competitive in their Medicare Advantage markets. New Medicare Advantage contracts, particularly those with over 1,000 members, need to begin focusing on quality measures early in order to remain competitive and attract enrollment within the Medicare Advantage market.

DATA AND METHODOLOGY

For this analysis, all contracts were pulled that received a Payment Year Star Rating[5] in any year from 2013 through 2020. Each contract with a Star Rating was designated "New" if it did not receive a star rating in the prior payment year, otherwise the contract was classified as "Existing."

For each star rating year, enrollment associated with a contract or parent organization was pulled from December of the performance year.[6]

APPENDIX A: TIMELINE FOR MEDICARE ADVANTAGE STAR RATINGS

The table below illustrates the various aspects of the Star Rating timeline, demonstrating the three-year lag between performance data being collected and payments based on this performance being made.

	2017	2018	2019	2020	2021	2022
Star 2018 *(Payment Year 2019)*[7]	Mar–May CAHPS Survey Sept/Oct **Star 2018 Announced**	Impacts Marketing & Sales Incorporated into June bid	$ Payment Received			
Star 2019 *(Payment Year 2020)*	Clinical, RX & Operational Measurement Apr–Jul HOS Survey *(with 2 yr cohort)*	Mar–May CAHPS Survey Sept/Oct **Star 2019 Announced**	Impacts Marketing & Sales Incorporated into June bid	$ Payment Received		
Star 2020 *(Payment Year 2021)*		Clinical, RX & Operational Measurement Apr–Jul HOS Survey *(with 2 yr cohort)*	Mar–May CAHPS Survey Sept/Oct **Star 2020 Announced**	Impacts Marketing & Sales Incorporated into June bid	$ Payment Received	
Star 2021 *(Payment Year 2022)*			Clinical, RX & Operational Measurement Apr–Jul HOS Survey *(with 2 yr cohort)*	Mar– May CAHPS Survey Sept/Oct **Star 2021 Announced**	Impacts Marketing & Sales Incorporated into June bid	$ Payment Received

APPENDIX B: REVENUE IMPACTS FROM STAR RATINGS

The remainder of the appendix is designed to give a brief background on some of the technical aspects of Medicare Advantage bids and how changes in quality star rating can impact a Medicare Advantage plan financially.

Table A1 below gives the breakdown of the Quality Bonus Payment and Rebate Percentage given at each quality star level, and Table A2 shows an example of a calculation for a plan's payment at both 3.0 Stars and 4.0 Stars.

Moving from 3.0 to 4.0 Stars, Plan H1234-567-000 receives a 5% increase in Benchmark and retains 15% more gross rebate. This increases the plan's total revenue from $850 PMPM to $894.25 PMPM. ■

Table A1
Quality Bonus and Rebate Percentages by Star Rating

Plan Rating	Bonus Payment	Quality Bonus Adjusted Benchmark	Rebate Percentage
5.0	5.0%	105% of Benchmark	70%
4.5	5.0%	105% of Benchmark	70%
4.0	5.0%	105% of Benchmark	65%
3.5	0.0%	100% of Benchmark	65%
3.0	0.0%	100% of Benchmark	50%
New Plans under New MAOs	3.5%	103.5% of Benchmark	65%
Plans Not Reporting	0.0%	100% of Benchmark	50%

Table A2
Sample Calculation for Plan H1234-567-000

	Original Values	Plan at 3.0 Stars	Plan at 4.0 Stars
Risk Score	1.1	1.1	1.1
Standardized Benchmark	900	900	=900*105% **=945**
Plan Benchmark *(at a 1.1 Risk Score)*		=900*1.1 **=990**	=900*1.1*105% **=1,039.5**
Standardized Bid	800	800	800
Plan Bid *(at a 1.1 Risk Score)*		=800*1.1 **=880**	=800*1.1 **=880**
Savings		110	159.5
Rebate Percentage		50%	65%
Plan Revenue		=$880 + $110*50% **=$935 PMPM**	=$880 + $159.5*65% **=$983.68 PMPM**

APPENDIX C: MOST IMPACTFUL MEASURES FOR NEW PLANS

Top Measures by Impact

	New and Large Parent Org	**Total Difference**		**(0.68)**
		A	*B*	*A * B*
		PY 2020 Measure Weight	**Difference**	**Overall Star Rating Impact**
1	Diabetes Care—Blood Sugar Controlled	3	(2.07)	(0.08)
2	Complaints About the Health/Drug Plan	2	(2.23)	(0.04)
3	Controlling Blood Pressure	3	(1.06)	(0.04)
4	Members Choosing to Leave the Plan	2	(2.10)	(0.04)
5	Customer Service	2	(1.40)	(0.03)
	New and Fast Growing	**Total Difference**		**(0.70)**
		A	*B*	*A * B*
		PY 2020 Measure Weight	**Difference**	**Overall Star Rating Impact**
1	Controlling Blood Pressure	3	(1.61)	(0.06)
2	Diabetes Care—Blood Sugar Controlled	3	(1.19)	(0.05)
3	Statin Therapy for Patients with Cardiovascular Disease	1	(2.26)	(0.03)
4	Medication Adherence for Diabetes Medications	3	(0.72)	(0.03)
5	Medication Adherence for Hypertension (RAS antagonists)	3	(0.71)	(0.03)
	All Other New	**Total Difference**		**(0.80)**
		A	*B*	*A * B*
		PY 2020 Measure Weight	**Difference**	**Overall Star Rating Impact**
1	Controlling Blood Pressure	3	(1.67)	(0.07)
2	Drug Plan Quality Improvement	5	(0.99)	(0.06)
3	Diabetes Care—Blood Sugar Controlled	3	(1.54)	(0.06)
4	Health Plan Quality Improvement	5	(0.53)	(0.03)
5	Medication Reconciliation Post-Discharge	1	(2.06)	(0.03)

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ENDNOTES

1 Using a member weighted average of contract star ratings from Payment Year 2013 through Payment Year 2020. Enrollment is pulled from the performance year on the star ratings.

2 Contracts experiencing a drop in revenue when they move from the New Contract 3.5% bonus payment to their first bonus payment based on the contract star rating.

3 Because Special Needs Plans (SNP) have more possible star measures, contracts were separated for the purpose of this analysis between contracts with low SNP enrollment—less than 25% of total contract enrollment in Special Needs Plans—and contracts with high SNP enrollment—greater than or equal to 25% enrollment attributable to Special Needs Plans.

4 "Large Parent Organization" is defined here as a parent organization having more than 200,000 members in the performance period.

5 "Payment Year Star Rating" is used to refer to the earned star rating that determines a contract's payment in that year. Ex: Payment Year 2016 Star Ratings were released in October of 2014, are referred to as Calendar Year 2015 Star Ratings by CMS, and determine payments for the 2016 contract year.

6 Ex: Contracts with Payment Year 2016 Star Ratings will have associated enrollment pulled from December 2013, as 2013 is the performance year for Payment Year 2016 Star Ratings.

7 Throughout this paper, Star Ratings are referred to as the year they impact MA Payments.

Leader Interview

With Andrew D. Rallis

Andrew D. Rallis, FSA, MAAA, is executive vice president and global chief actuary of MetLife and the 2019–2020 president of the Society of Actuaries. He is responsible for actuarial practice throughout MetLife, with more than 1,200 actuaries operating across 46 countries. He is chair of MetLife's captive reinsurers and co-chair of several of the company's risk committees. He also serves as the president of the Chief Actuaries Forum, an industry group representing the largest employers of actuaries.

ON BEING AN ACTUARY

Health Watch (*HW*): How and when did you decide to become an actuary?

Andrew D. Rallis (ADR): I first learned of the profession in high school. I attended Stuyvesant High School in New York City, a school offering a curriculum concentrated in science and math. There was a special program on advanced math topics I was able to attend and one of the speakers described actuarial work. It became one of my top two career choices.

***HW*: What other careers did you consider? Or if you have had other careers, can you describe them?**

ADR: My other top choice was a career in physics, probably focused on astrophysics. I worked as part of a research team as an undergraduate at MIT [Massachusetts Institute of Technology] and got to experience it firsthand. A career in science requires a narrow focus. I wanted to use my skills in a way that could help people more directly.

***HW*: What was your favorite job before you became an actuary?**

ADR: Definitely, it was the undergraduate research job. My thesis even wound up getting published in the *Astrophysical Journal*. It was a survey of X-ray sources in a nearby galaxy.

***HW*: What has been most crucial in your development as an actuary?**

ADR: Passing the exams! Probably that's too obvious, but it was quite challenging balancing work and exams for many years.

***HW*: Looking at your career as an actuary, do you see any important learning milestones or turning points in your career?**

ADR: Very early in my career, I decided I would challenge conventional ways of getting my work done. I tried to apply what I was learning on exams to my day-to-day job. For example, when we had to reprice some one-year term attained-age life insurance, I formulated the problem as a series of equations to optimize and used the simplex algorithm I learned to solve in numerical analysis. No one told me to do this, and my managers didn't really understand what I was doing, but it worked!

***HW*: As an actuary, what keeps you awake at night?**

ADR: I don't sleep (just kidding!). We have the fate of the financial well-being of our principal stakeholders and the general public in our hands. This is an awesome responsibility, and it requires constant vigilance for internal and external risk factors.

ON BEING A LEADER

***HW*: How much did your actuarial training prepare you for this role? What additional training—formal, informal, or otherwise—did you need to be successful?**

ADR: My actuarial training itself didn't prepare me directly for the role of being a leader. It required the mentorship of leaders before me, and ultimately deeper and deeper development of those skills with some external coaching. At the core of it all is

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having the courage to take a stand on things that matter to you, in life or work.

***HW*: What are the most important lessons you've learned in your role?**

ADR: You have to trust others. Letting go of work that you enjoy and are comfortable with to make room for work that is more difficult and uncomfortable is the best way to grow.

***HW*: Let's say you're hiring your successor. If you're presented with two actuaries with equivalent experience and training, what characteristics will help you choose one over the other?**

ADR: It's table stakes that an actuary has the right technical background. I would look closely at the actuary who has demonstrated qualities that I think are most important for being viewed as a trusted adviser. These are integrity, excellence, creativity, listening skills and resilience.

***HW*: Describe the biggest one or two challenges that you have faced in your role.**

ADR: The attribute of resilience is very important. If the other attributes disappear when times are tough, then you can't be an effective adviser. My biggest challenges have been informing senior management and our board of directors of large movements in balance sheet items due to assumption updates or even mistakes. Those are times when you want to hide under a rock but the only way to handle the situation is with the utmost integrity, including being completely transparent and getting to the right answer quickly.

***HW*: What advice would you give to another actuary going into a leadership position for the first time?**

ADR: I like to say, the only thing harder than the math we do, is dealing with people. People are unpredictable. So, to be an effective leader, you need to connect with people at a personal level. ■

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